



Presentation to the Senate Health and Human Services Committee

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Overview

- Medical Transportation Program overview
- Medicaid prior authorization overview for acute care services
- Medicaid orthodontia claims background
- Office of Inspector General (OIG) activities

Medical Transportation Program

Medical Transportation Program (MTP)

- MTP is a federally-required service that arranges non-emergency medical transportation to health service appointments for Medicaid clients who do not have other means of transportation
- In 2011, approximately 350,000 clients were served through over 9 million trips, arranged through over 5 million calls
- HHSC recently commissioned an audit to determine areas needing improvement and found problems with both MTP's policies and authorization procedures

MTP: Service Delivery

- MTP authorizes services when they receive a client request through call centers in San Antonio, Austin, Grand Prairie, and McAllen
- MTP staff is responsible for arranging the most appropriate, cost-effective means of transportation that meets the client's health care needs, which may include:
 - Distributing bus tickets or voucher for public transportation
 - Arranging transportation with contracted providers
 - Transportation Service Area Providers (TSAPs) are traditional transportation providers and can be either private or public entities
 - Processing payment directly to clients (or someone that transports them) as a reimbursement or in advance
 - Individual Transportation Providers (ITPs) are often friends and family members of Medicaid recipients
 - Arranging meals and lodging services
 - Arranging out of state travel, if treatment requires it

Audit Findings and Response

Finding

- TSAPs and ITPs were not always fully monitored based on the level of program risk

Action Planned

- Revise the MTP contract quality assurance process to more effectively use resources and meet program objectives. The revised contract QA process will include a risk-based process. Those transportation providers that pose greater risk, either based on past performance on contract value, will be audited more closely
- Redesign policies, procedures, and operation manuals to ensure documentation of issues
- Implement a monitoring plan for all MTP contracts

Audit Findings and Response

Finding

- During the period 2008 through 2011, advance funds increased from \$19 million to \$53 million

Action Planned

- Revise this program to revert to a reimbursement rather than an advance funds program
- Develop an automated solution for matching transportation service claims
- Develop monitoring processes to review transportation claims with no corresponding healthcare claim or encounter record
- Develop process for recoupment of funds when rules are not met
- Focus resources on review of data analysis trends and monitoring to ensure appropriate use of services

Audit Findings and Response

Finding

- The advance funds contractor is reimbursed a flat fee for each transaction
- In some cases, rather than bundling a series of advance funds, the contractor charged a separate fee for each

Action Planned

- The advance funds contract is undergoing an audit by OIG. If any funds were incorrectly paid, those will be recouped
- When the advance funds program is re-designed to be based on reimbursement, these services will be performed in-house rather than through the advance funds contractor

Audit Findings and Response

Finding

- MTP does not have clear and consistent policy, or associated processes, to provide guidance to staff about when and how to address non-compliance with rules or suspected fraud or abuse

Action Planned

- Develop policies regarding criteria for client service limitations
- Develop interface to provide staff information regarding additional review for services
- Implement internal controls for screening staff prior to hiring

Audit Findings and Response

Finding

- Automated functionality and controls do not adequately support enforcement of policy and effective monitoring of contractors

Action Planned

- Re-write authorization system to strengthen controls for service authorization
- Transition enrollment of provider types and claims processing to the Medicaid Claims Administrator
 - Texas Medicaid and Healthcare Partnership, (TMHP)
- Incorporate contracts into existing agency contract monitoring systems

Medicaid Prior Authorization

Medicaid Prior Authorization Overview for Acute Care Services

- Some services that providers have determined are medically necessary also require prior authorization in Medicaid.
- Medically necessary services are activities which may be justified as reasonable, necessary, and/or appropriate, based on state Medicaid policies.
- Prior authorization is a process in which providers obtain approval prior to initiating services.
- Some Medicaid services require prior authorization as a condition for payment; however, it is not a guarantee of payment.
- Prior authorization determinations for Medicaid acute care services are made by:
 - The Texas Medicaid & Healthcare Partnership (TMHP) as the Medicaid claims administrator.
 - Managed care organizations (MCOs) throughout the state.

Medicaid Prior Authorization Overview

TMHP prior authorization process:

1. A provider submits a complete prior authorization request with all required documentation.
2. TMHP determines if the request meets current medical necessity criteria.
3. Once the review is complete, the provider and the client are both notified of the outcome.

Medicaid Prior Authorization Overview

Managed care prior authorization process:

- Each individual MCO is required to provide the base scope of benefits available in the Medicaid acute care program.
- The MCO can determine what restrictions or limitations to place on those benefits, which includes prior authorization.
- The MCO is required to ensure that all services provided through its plan meets medical necessity criteria.

Medicaid Prior Authorization Overview

Services that require prior authorization:

All clients:

- Non-emergency ambulance transports
- Substance use disorder detoxification and residential treatment services
- Durable medical equipment
- Oxygen and respiratory equipment
- Skilled nursing and home health aide visits
- Transplants
- OB ultrasounds and electrocardiograms when over limits
- Implantable infusion pumps
- Physical and occupational therapy in the home
- CT and MRI imaging procedures

Clients 20 years of age and under:

- Inpatient psychiatric admissions
- Inpatient rehabilitative services
- Private duty nursing services
- Physical, occupational and speech therapy
- Personal care services
- Nutritional counseling
- Orthotics and prosthetics
- Therapeutic dental services and orthodontics
- Vitamins and Minerals

Medicaid Orthodontia Claims

Medicaid Orthodontia Claims: Background

- Concerns have been raised about the high utilization of Texas Medicaid orthodontia services.
- Allegations have been about both Medicaid policies and management of the prior authorization process by TMHP.

Medicaid Orthodontia Claims: Policy

- Medicaid policy limits orthodontic services (including braces) to treatment of medically necessary cases:
 - Children ages 13 and older with severe handicapping malocclusion (a misalignment of teeth that causes the upper and lower teeth not to fit together correctly).
 - Children ages birth through 20 with cleft palate or other special medically necessary circumstances.
- Medicaid policy does not allow orthodontia for cosmetic reasons.

Medicaid Orthodontia Claims: Expenditure Increases

- In response to *Frew v. Suehs*, the 2007 Texas Legislature appropriated \$1.8 billion to expand access to preventative services in children's Medicaid including medical and dental checkups and services.
- HHSC significantly increased outreach and dental reimbursement rates with the intent of increasing utilization.
- From 2008 to 2010, Medicaid expenditures for orthodontic care increased from \$102 million to \$185 million.
 - In 2007, 38.5 percent (1.1 million) children with Medicaid received dental services.
 - In 2010, 51.6 percent (1.6 million) children with Medicaid received dental services.

Medicaid Orthodontia Claims: Prior Authorization Management

- HHSC contracts with TMHP for Medicaid claims administration activities (including processing claims, enrolling providers, etc.).
- HHSC reviewed TMHP's prior authorization evaluation process and identified areas where improvement was necessary:
 - Review and retention of clinical information.
 - Collection of additional clinical information.
 - Employment of sufficient and qualified staff.

Medicaid Orthodontia Claims: Prior Authorization Management

- TMHP has already made staffing changes.
 - In September 2011, TMHP terminated the former dental director.
 - TMHP hired a new dental director, four orthodontists, and additional staff within the dental prior authorization unit.
- HHSC is addressing performance issues through contract requirements.

Medicaid Orthodontia Claims: Contract Quality Assurance

- The contract quality assurance process has been revised to include additional factors including staff qualifications, volume, and accuracy.
- Staff qualification metrics will ensure staff with the correct knowledge review prior authorization requests, if staff volume is reasonable given the number of prior authorization requests, and a quality component has been added.
- Each quarter, a random sample of TMHP-approved orthodontia prior authorizations will be used to assess approval process accuracy.
- HHSC is in the process of hiring a full-time Medicaid and CHIP dental director.

Medicaid Orthodontia Claims: Audit Activities

- The federal and HHSC Office of Inspector General (OIG) are auditing the TMHP orthodontia prior authorization process.
- Both audits are expected to be completed in the next 6 to 12 months.
- If the TMHP approved services do not meet state criteria, HHSC will recover service costs from TMHP.
- If the audit finds a dentist submitted incorrect information to get services approved, HHSC will seek provider reimbursement.
- Any cases involving suspected fraud will be referred to the Office of the Attorney General for handling.

Medicaid Orthodontia Claims: Policy Review

- HHSC determined Medicaid orthodontia reimbursement policy allowed for unlimited visits for maintenance of orthodontic devices, which could provide an incentive for more visits than necessary.
 - Average number of visits for a child receiving orthodontia services exceeded 22 per year, while typically 12 visits per year is expected.
- HHSC is revising this policy to allow for global orthodontia payments.
 - Payments will be based on the level of severity as well as several other changes to strengthen policy weaknesses.

Medicaid Orthodontia Claims: Policy Changes

- Effective October 1, 2011, dentists must submit full-cast dental models with all orthodontia requests. This is in addition to the radiographs, photos, and other documentation already required.
- Performance of Medicaid orthodontic services will soon be limited only by board certified orthodontists, pediatric dentists, or general dentists with 200 hours of continuing dental education in orthodontics.
- HHSC is planning to offer a bundled rate for orthodontic services that includes all services related to the orthodontia service.

Medicaid Orthodontia Claims: Implementing Dental Managed Care

- The state required the dental plans to submit their prior authorization policies for review and approval with the goal of ensuring orthodontic services delivered are medically necessary.
- Dental plans conduct provider profiling and look for unusual trends in service delivery.
- Special Investigative Units track, trend, and report possible fraud, waste, and abuse.
- Dental plans are required to follow Medicaid/CHIP dental policies.

Medicaid Orthodontia Claims: OIG Activities

Medicaid Orthodontia Claims: OIG Review Systems

- Surveillance and Utilization Review System (SURS)
 - Dental services (including orthodontia) are included in the federally required SURS claims processing system component.
 - There are no unique SURS line items for orthodontia specific services since the prior authorization process is the front-end utilization review for these services.
- The Medicaid Fraud and Abuse Detection System (MFADS) has several dental targeted queries that include orthodontia services billed outside of published policy.
 - MFADS also has a dental model that includes orthodontic providers.
 - The billing patterns for this provider group are fairly consistent among the specialty.

Medicaid Orthodontia Claims: OIG Credible Allegation of Fraud

- Credible Allegation of Fraud (CAF)
 - Pursuant to recent Federal rules, OIG has implemented policies and procedures to suspend all Medicaid payments to a provider after OIG determines that a credible allegation of fraud exists for which an investigation is pending.
 - OIG began placing its first payment suspensions in June and July of 2011.
 - Currently, OIG has issued a total of eleven payment suspensions.
 - All allegations are forwarded to the OAG Medicaid Fraud Control Unit.

Medicaid Orthodontia Claims: Coordination with the Board of Dental Examiners

- HHSC OIG provides information to the Dental Board when OIG finds that a dentist has committed Medicaid fraud or abuse.
- HHSC OIG accesses the Dental Board's website for the license status of dental providers during the provider enrollment and screening process.

Medicaid Orthodontia Claims: Coordination with the Board of Dental Examiners

- HHSC OIG maintains a Memorandum of Understanding with the Texas Board of Dental Examiners
 - The Board meets four to six times per year to ratify disciplinary board orders.
 - If a dentist loses his or her licensure, the Board sends a copy of the order to OIG for further action.
 - OIG excludes the provider from the Medicaid program based upon the licensure loss. OIG estimates that it excludes approximately 20 dentists per year on this basis.